GENERAL PRESCRIPTION REFERRAL FORM

www.medboxrx.com

Phone: **844-840-1758**
Fax: 844-840-1759
Email:contact@MedBoxRX.com

Date Medication Needed: ______________ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up (store location): ______________ Injection training by pharmacy?

1: Patient Information

Patient Name: ______________ **Birthdate:** ______________
Sex: ○ Male ○ Female **Height:** ______ **Weight:** ______ ○ lbs. ○ kg.
Soc. Sec. #: ______________ **Preferred Phone:** ______________
Known Allergies: ______________
Address: ______________
City: ______________ **State:** ______ **Zip:** ______
Alternate Caregiver Name: ______________
Preferred Phone: ______________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name(s):

☐ ______________ **DEA#:** ______ **NPI#:** ______
☐ ______________ **DEA#:** ______ **NPI#:** ______
☐ ______________ **DEA#:** ______ **NPI#:** ______
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☐ ______________ **DEA#:** ______ **NPI#:** ______

Practice Info:

Practice Name: ______________
Address: ______________
City, State: ______________
Zip: ______________ **Tax ID#:** ______________
Phone: ______________ **Fax:** ______________
Key Contact: ______________
Key Contact Phone: ______________
Key Contact Email: ______________

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: ______________ ICD-10: ______________

4: Prescription Information

Medication	Dose/Strength	Max. Dally Dosage	Sig	Qty.	Refills
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Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: ______________ Date: ______________

Prescriber Signature: Prescriber, please sign and date below

Dispense as written ______ Date ______ Substitution Permissable ______ Date ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: ______________

By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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